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Fifth District

April 18, 2005

To: Supervisor Gloria Molina, Chair  
Supervisor Yvonne B. Burke  
Supervisor Zev Yaroslavsky  
Supervisor Don Knabe  
Supervisor Michael D. Antonovich

From: David E. Janssen  
Chief Administrative Officer

**HEALTH AUTHORITY BLUE PRINT – PRELIMINARY REPORT**

At the Board meeting of January 11, 2005, my office was instructed to: 1) develop a draft Health Authority Blue Print which would address various issues and serve as a workable plan for the possible implementation of a health authority to run the County's entire hospital system, along with a proposed milestone-level action plan, timetable and budget, 2) review available previous studies and reference materials and consult with key contributors to past studies and other knowledgeable authorities, 3) have the County's Legislative Advocates work with members of the State Legislature to draft an appropriate bill relating to the possible creation of a health authority within Los Angeles County, and 4) report back on the experiences of other jurisdictions such as Alameda County and Denver to understand how they are working and what might work effectively within Los Angeles County.

Staff from my office, County Counsel, and the Department of Health Services (DHS) have been assembled to work on this issue, and have coordinated with the County's Legislative Strategist and outside parties via the Governance Task Force of the LA Collaborative. The LA Collaborative is a project of The California Endowment to improve communication and planning between the public and private health sectors in Los Angeles.

## Background

The issue of whether to create a health authority and/or develop an alternative governance structure for DHS is not new. Over the past ten years, four possible governance options have emerged:

Health Commission – a formal body created by the Board and assigned specific oversight responsibilities, but with DHS facilities still owned and operated by the County.

Health Authority – a legislatively-established public entity, distinct from the County, that assumes operational control of DHS facilities under contract with the County.

Private Non-Profit Public Benefit Corporation – a private non-profit entity, distinct from the County, that assumes operational control of DHS facilities under contract with the County.

Health Care District – a special governmental district (formerly known as a hospital district) formed pursuant to State law that assumes operational control of DHS facilities under contract with the County.

Additionally, a number of studies have examined the issue with some or all of the following goals: 1) improvement of overall health system planning, coordination and oversight, 2) increased operational and managerial flexibility for DHS facilities, 3) increased system efficiencies and revenues, and 4) enhanced long-term community and political support for the health system. A summary of prior reports can be found in Attachment I.

In February 2002, the Board adopted the recommendations of the Ad Hoc Hearing Body on Governance to provide DHS with greater administrative authority and flexibility to pursue strategies to improve DHS' fiscal situation, and if improvements do not occur for DHS within a year, revisit exploration and consideration of a health authority for DHS.

Administrative Authority and Flexibility. Since 2002, the Board and my office have provided DHS with increased administrative authority in contracting, fiscal management, and personnel. In contracting, where appropriate, DHS has been provided expanded authority to execute certain agreements without subsequent approval by the Board. DHS' budget authority has been expanded by allowing the CAO to approve adjustments of up to \$1 million in each budget unit (e.g., LAC+USC, AIDS, Public Health) per quarter. (For other County departments, this authority is limited to \$250,000 per quarter.) Additionally, DHS' personnel authority has been expanded to allow for hiring

and promotions (except management and special pay situations) without prior CAO or Board approval if there are enough funds budgeted and the position is on the Board-approved staffing ordinance.

Recently Adopted Governance Changes. On February 22, 2005, the Board adopted the recommendation of Navigant Consulting to change governance for King/Drew Medical Center (KDMC) and create a Hospital Advisory Board (HAB). Under this model, the County retains ultimate authority for the quality of care and the operation of KDMC, but specific responsibilities have been delegated to the HAB to provide policy-level direction and oversight of KDMC. The HAB is a "commission" type of change in governance.

DHS Fiscal Situation. DHS has a looming deficit of \$435.4 million beginning in Fiscal Year 2006-07, and, if unmitigated, the deficit rolls forward to \$1.4 billion by Fiscal Year 2008-09. The shortfall, a result of steep increases in health care costs and declining or expiring Medicaid revenues, is occurring despite the County's best efforts to streamline operations, identify other Medicaid revenues, as well as County voters' willingness to tax themselves to preserve the health system through the enactment of Measure B.

In June 2002, the Board adopted a plan to reform the County health care system to achieve \$357.5 million in cost reductions. In November 2002, the voters overwhelmingly approved a property tax increase which provides about \$170 million annually to support trauma care and bioterrorism preparedness. In addition, County, State and Federal governments have worked collaboratively to provide \$250 million in **one-time assistance**. While these actions have helped to narrow the budget gap, **an underlying structural imbalance remains between the rising cost of health care and revenue sources that are increasingly uncertain**. Recent examples of revenue uncertainty include the current Congressional consideration of substantial Medicaid reductions, and the State's ongoing negotiations with the Federal government to revamp Medi-Cal hospital payments.

### Legislative Developments

Two bills have been introduced in the Legislature that address the issue of DHS governance.

AB 166 (Ridley-Thomas), as introduced on January 19, 2005, would authorize Los Angeles County, by ordinance, to establish a "hospital authority" to "manage, administer, and control" the DHS health care facilities. The bill is patterned on the State Health and Safety Code provisions which authorized the Alameda County Medical Center Hospital Authority. Among the bill's key provisions are:

- The Board of Supervisors would have appointing power for the authority board.

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- The Board of Supervisors would have the authority to specify the size, qualifications, term of office and removal process for the authority board.
- The Board of Supervisors would be required to adopt bylaws related to the operation of medical centers under the authority.
- The authority would be a public agency and could have legal ownership of facilities.
- The authority would not be governed by, or subject to policies or operational rules of the County including, but not limited to, personnel and procurement.
- Any liabilities or obligations made by the authority could not be shifted to the County.
- The authority would be required to recognize represented employees and their organizations under the Myers-Milias-Brown Act.
- The development of a personnel transition plan for employees, and a requirement that the authority abide by the County's contracts with labor organizations until expiration, when successor agreements would be solely negotiated by the authority.
- Maintenance of access to patient care revenues and subsidies (e.g., Medi-Cal Disproportionate Share Hospital payments, Proposition 99 funds) currently received by DHS facilities.
- The County retains the "ultimate responsibility" for indigent care under Section 17000 of the State Welfare and Institutions Code.
- Any agreement between the County and the authority must ensure that all existing services continue to be provided subject to the policy of the County and the County's obligations under Section 17000.

The bill is a non-urgency measure, and if enacted this session would become effective January 1, 2006. It was referred to the Assembly Committees on Health and Local Government, and is scheduled for hearing in the Health Committee on April 26, 2005.

AB 201 (Dymally), as introduced on January 31, 2005, would authorize Los Angeles County to establish, by ordinance, a health authority to provide or contract for the provision of health care benefits to eligible persons. Among the bill's key provisions are:

- The Board of Supervisors would have appointing power for the authority board.
- The authority board shall consist of 13 members – five designated by the Board of Supervisors, three nominated by the Governor, three nominated by the Governor representing the University of California, the University of Southern California, and Drew University of Medicine and Science, one nominated by the Speaker of the Assembly, and one nominated by the Senate Rules Committee. (The bill also specifies a member to be appointed by the authority representing the community which suggests the overall membership of the authority board would be 14.)

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- The authority would have oversight responsibility for local hospital services, ambulance medical services, public health services, and emergency medical services, and potentially school clinics, mental health services and correctional health services at the discretion of the Board of Supervisors.
- The authority would be a public agency and could directly provide or contract for services.
- The authority would be responsible for the establishment of standards of care consistent with prevailing community health care standards;
- The authority would not be governed by, or subject to policies or operational rules of the County including, but not limited to, personnel and procurement.
- Any liabilities or obligations made by the authority could not be shifted to the County.
- The development of a personnel transition plan for employees, and a requirement that the authority abide by the County's contracts with labor organizations until expiration, when successor agreements would be solely negotiated by the authority.
- The County is not relieved of responsibility for indigent care under Section 17000 of the State Welfare and Institutions Code.

The bill is a non-urgency measure, and if enacted this session would become effective January 1, 2006. It was referred to the Assembly Committees on Health and Local Government with no hearing date scheduled.

**Discussion.** Both AB 166 and AB 201 would allow the creation of a health authority that could operate DHS facilities at the option of the County. However, the success of this approach will be heavily dependent on its underlying financial fitness, how the roles and responsibilities are defined in an operational and funding agreement with the County, and whether the new structure can reasonably control costs within the funding level provided.

Moreover, it does not make sense to simply transfer the structural deficit of the current DHS system to a new authority and expect funding problems to go away. While on the margin a new model may be better able to moderate health care cost pressures and increase the number of patients with third party coverage, the authority will still be subject to the County's ability to finance indigent care and an environment where there are ongoing threats to key revenue streams such as Medicaid.

**Therefore, the Board should consider requesting amendments to AB 166 and AB 201 to include access to a new independent revenue base (e.g. sales or alcohol taxes) to support the mission of the new authority and the County's Section 17000 mandate.**

### **Review of Other Jurisdictions**

Attachment II provides a summary of alternative governance models in other jurisdictions. We are working with the Governance Task Force of the LA Collaborative to increase our understanding of the operation of these models and will report back within 60 days.

### **Update of Implementation Framework for Models**

As requested, we have developed a milestone-level action plan for four possible governance structures – health commission, health authority, private non-profit public benefit corporation, and health care district. That action plan is Attachment III.

Additionally, we are working to develop answers to the detailed questions raised in the Board January 11, 2005 instruction, and are also working with DHS to develop updated information on transition costs for the health authority models and will report back within 60 days.

### **Conclusion**

The DHS health system has a massive structural financial deficit that outstrips the County's financial capacity to resolve. At the same time, the Board needs to be assured that the County's health system is rationally planned and managed, efficient and achieving maximum value regardless of its funding level. A change in the governance of DHS could help support the Board's role in achieving this objective. The Board's recent action to create the King/Drew Hospital Advisory Board (HAB) is a step in this direction for a specific facility. The progress of the HAB should be monitored and evaluated to determine if it is a model that warrants application to the entire DHS system.

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### **Attachments**

- c:      Executive Officer, Board of Supervisors  
            County Counsel  
            Director of Health Services  
            Legislative Strategist

**Attachment I**

**SUMMARY OF REPORTS REGARDING GOVERNANCE OF THE LOS ANGELES COUNTY DEPARTMENT OF  
HEALTH SERVICES**

YEAR	REPORT	SUMMARY
July 1995	<b><i>Report of the Health Crisis Task Force</i></b>	<p>Recommended the Board constitute a semi-autonomous health authority run by recognized health policy experts to guide implementation of the County's broad health care policies.</p> <p>The Department of Health Services (DHS) would report to the Authority and would remain responsible to the Board, but function independently based on agreed guidelines.</p>
December 1995	<b><i>Governance of the Department of Health Services</i></b>  Los Angeles County Health Crisis Manager	<p>Recommended the creation of a 7-member semi-autonomous health authority that would have responsibility for developing and presenting major policy and implementation recommendations to the Board, which could ratify recommendations by a yes or no vote.</p> <p>Panel members would be appointed by the Board, serve on a voluntary basis, and have recognized expertise in the health field.</p> <p>The health authority would meet bi-weekly to receive budget and policy reports from DHS. DHS would continue to report to the Board regarding day-to-day management, and the health authority would have delegated authority to approve contracts up to a set amount, without Board ratification.</p> <p>Priority areas of focus for the health authority include analysis of the DHS budget, development of ways to respond to changes in health care financing, and access to funding strategies to meet future health service needs.</p>
September 2000	<b><i>Los Angeles County Blue Ribbon Health Task Force Report</i></b>	<p>Recommended that the Board of Supervisors initiate an independent study to evaluate current governance of the Department of Health Services and explore other options for its oversight.</p> <p>Recommended consideration of options such as a public benefit corporation, and independent health authority, models that allow for separate governance of hospitals and clinics, and/or public private partnership models.</p>

YEAR	REPORT	SUMMARY
		Report also recommended operational improvements for DHS including creation of a strategic and operational plan, increased managerial and budget authority, reduced barriers to effective human resource and materials management, increased investment in information technology, and enhanced leadership and training development.
August 2001	<b>Governance of the Department of Health Services</b>  Los Angeles County Chief Administrative Office	<p>Extensive review of four possible governance structures – health commission, health authority, private non-profit public benefit corporation, and health care district, and case study examples of health systems that operate under the each of the four models.</p> <p>Provided discussion of significant financial and transition issues including fiscal responsibility for the Section 17000 mandate, access to Medi-Cal supplements, payments, labor and personnel, and vendor agreement with other County departments.</p> <p>Recommended that, given the length of time involved in creating a health authority, the Board should, and may within in its existing powers, provide DHS with greater autonomy over contracting, personnel, and fiscal management.</p>
December 2001	<b>Administrative Flexibility Proposals for the Department of Health Services</b>  Los Angeles County Chief Administrative Office	<p>Outlined four areas that would provide DHS with more administrative flexibility – delegated authority to solicit and execute certain types of contracts, CAO (rather than Board) approval of budget adjustments of up to \$1 million per quarter, specified exemption from the hiring and promotion freeze policy, and authorization on a case-by-case basis to manage certain capital projects.</p>
February 2002	<b>Action Plan and Estimated Timetables for Conversion to Alternative Health Governance Models</b>  Los Angeles County Chief Administrative Office	<p>Illustrated the major steps and timeframes associated with creating three possible governance structures – health authority, health district, and private non-profit public benefit corporation. Each structure could take up to about two years to create, and 3-5 years to fully transition.</p> <p>Report also noted that a health commission model could be created by Board ordinance and become operative 30 days after the second reading of the ordinance.</p>
February 2002	<b>Final Report Ad Hoc Hearing Body on Governance</b>	<p>Reviewed August 2001 CAO report, summarized public input, and recommended the Board not make a change in DHS governance at the time, but rather make improvements in the current governance structure.</p> <p>Recommended improvements include the expedited implementation of the 2000 Blue Ribbon Health Task Force recommendations related to the operation of DHS, and establishment of a Financing Oversight Advisory Group to develop recommendations related to enhancing DHS revenues.</p>

YEAR	REPORT	SUMMARY
		Further recommended that if improvements to the current system do not occur within 12 months, that over the next year, the Board should explore the desirability and feasibility of establishing a health authority to govern DHS.
June 2002	<b>Redesign of the Department of Health Services</b>  Los Angeles County Department of Health Services	Recommended creation of a public authority that would allow Rancho Los Amigos National Rehabilitation Center to continue to operate under the governance of a public entity, but not under the auspices of Los Angeles County.  Recommended the County pursue substantial reform to the compensation and civil service status of DHS managerial and clinical personnel to better link compensation to performance and productivity.
May 2003	<b>An Analysis of Alternative Governance for the Los Angeles County Department of Health Services</b>  University of Southern California	Extensive review of the DHS governance issue and options.  Recommends the creation of an independent authority by the Legislature in cooperation with the County to operate DHS, with the exception of certain public health functions. Mental health and alcohol and drug services would also be included under the authority.  Under the model, the County would have appointing power for the board of the authority, be required to contract with the authority for indigent care, and retain responsibility for the Section 17000 mandate.
January 2005	<b>King/Drew Medical Center Assessment Report</b>  Navigant Consulting	The authority would assume control of administrative, contracting, personnel management, and clinical service delivery responsibilities.  Recommended that the Board continue to explore implementation of a health authority to govern the entire County health system.
		Recommended that the Board immediately transfer oversight responsibility of King/Drew Medical Center (KDMC) to the existing KDMC Advisory Board, which would oversee clinical and educational programs, develop a strategic plan, assess financial performance, appoint KDMC executives, and make recommendations to increase quality of care, accountability, and operational efficiency at the facility.  The Advisory Board would be expanded to allow for greater health and financial expertise; members would meet monthly, report to the Board of Supervisors on at least a quarterly basis, and serve initial three-year terms.

**Attachment II**

**SUMMARY OF ALTERNATIVE HEALTH GOVERNANCE IN OTHER METROPOLITAN AREAS**

	Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
<b>Background</b>	<ul style="list-style-type: none"> <li>Separate public entity</li> <li>Alameda County Medical Center</li> <li>Established in 1998</li> </ul>	<ul style="list-style-type: none"> <li>Public benefit corporation</li> <li>New York City Health and Hospitals Corporation (HHC)</li> <li>Created in 1970</li> </ul>	<ul style="list-style-type: none"> <li>Separate public entity</li> <li>Denver Health &amp; Hospital Authority</li> <li>Established in 1997</li> </ul>	<ul style="list-style-type: none"> <li>Separate public entity</li> <li>Jackson Health System (JHS)</li> <li>The Public Health Trust is the governing body</li> <li>Established in 1973</li> </ul>	<ul style="list-style-type: none"> <li>Hospital District</li> <li>Parkland Health &amp; Hospital System</li> <li>Established in 1954</li> </ul>	<ul style="list-style-type: none"> <li>Separate public entity</li> <li>The MetroHealth System</li> <li>Established in 1989</li> </ul>	<ul style="list-style-type: none"> <li>Public Benefit Corporation</li> <li>Hennepin Healthcare System (HHS) – proposed name</li> <li>Proposed transfer in 2006; State statute had not been passed as of March 2005</li> </ul>
<b>Descriptives</b>	<ul style="list-style-type: none"> <li>236-bed Level II trauma center and teaching hospital with outpatient clinics, 159-bed acute rehabilitation center, 80-bed psychiatric hospital, and three free-standing ambulatory care centers</li> <li>Size of health system (facilities and utilization)</li> <li>Number of employees</li> <li>Annual budget</li> </ul>	<ul style="list-style-type: none"> <li>11 acute care hospitals, six diagnostic and treatment centers, four long-term care facilities, a home health agency, and more than 100 community health clinics</li> <li>Serves approximately 1.2 million patients annually, including more than 200,000 inpatients</li> <li>In FY 2003, provided about 5 million outpatient visits</li> <li>More than 80,000 emergency and trauma visits and 200,000 outpatient visits annually</li> <li>2,800 employees, including 460 physicians</li> <li>\$400 million budget</li> </ul>	<ul style="list-style-type: none"> <li>349-bed teaching hospital, 10 community health centers, 13 school-based clinics, five dental health clinics, public health department</li> <li>Served 160,000 patients in 2003</li> <li>4,000 employees</li> <li>Annual budget of \$400 million+</li> </ul>	<ul style="list-style-type: none"> <li>Jackson Memorial Hospital a 1,567-bed, tertiary, medical/surgical hospital, 12 primary care centers, two long-term care facilities, one community hospital, one community diagnostic center, seven school-based programs, and seven clinics in correction facilities</li> <li>10,500 employees</li> <li>\$15 billion budget</li> </ul>	<ul style="list-style-type: none"> <li>985-bed Parkland Memorial Hospital, 10 community-based comprehensive health centers, and other specialty health facilities</li> <li>Primary teaching institution for the University of Texas Southwestern Medical School</li> <li>In 2003, admitted 42,000 patients and treated 1 million patients through its emergency room and health centers</li> <li>7,000 employees</li> <li>Total budget of \$840 million in FY 2004-2005</li> </ul>	<ul style="list-style-type: none"> <li>MetroHealth Medical Center, a 731-bed hospital and level 1 trauma center, a comprehensive outpatient surgery center, two long-term care/skilled nursing centers, and 10 community health sites</li> <li>Affiliated with Case Western Reserve University School of Medicine</li> <li>In 2003, had 27,600 inpatient stays, 8,000 observation stays, and 658,000 outpatient visits</li> <li>6,000 total employees</li> <li>Annual operating budget of \$500 million</li> </ul>	<ul style="list-style-type: none"> <li>Hennepin County Medical Center (HCMC)</li> <li>Nearly 400,000 patient visits annually</li> <li>Medical education program</li> <li>Level 1 trauma center</li> <li>4,000+ employees</li> <li>Annual budget of \$375 million</li> </ul>
<b>Safety Net Responsibility</b>	<ul style="list-style-type: none"> <li>Is there a local responsibility?</li> <li>How is it ensured?</li> <li>How is it financed?</li> <li>Enabling statute specifies that the authority will provide</li> </ul>	<ul style="list-style-type: none"> <li>Counties are legally required to provide and pay for health care for low-income residents who are not supported or relieved by others (interpretation of this duty varies by county)</li> </ul>	<ul style="list-style-type: none"> <li>All social service districts in New York State, including New York City, are responsible for the care and assistance for people in the district who are in need of public assistance and care and who are unable to</li> </ul>	<ul style="list-style-type: none"> <li>State law requires counties to provide temporary medical services to the poor, but county obligations are limited to the amount of county appropriations</li> <li>Transfer agreement specifies that the authority will provide</li> </ul>	<ul style="list-style-type: none"> <li>Counties are only liable for emergency hospital care provided to their residents at out-of-county facilities</li> <li>All hospitals, including Jackson Memorial, are obligated to provide emergency treatment to all indigent Florida Commission but</li> </ul>	<ul style="list-style-type: none"> <li>No state or local responsibility to provide medical services to low-income persons; obligations limited to specific programs</li> <li>As a DSH hospital, MetroHealth is obligated to provide free care to indigent</li> </ul>	<ul style="list-style-type: none"> <li>No responsibility of local government to pay for health care provided to the poor</li> <li>Lease would require provision of health care services for the indigent through an agreement with the county</li> <li>Volume-based</li> </ul>

Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
<p>indigent care mandate remains with the county – not the authority</p> <ul style="list-style-type: none"> <li>• County provides the authority with an annual block grant for services provided to the indigent (based on the average number of indigent patients served in the prior three years)</li> <li>• Authority also receives about \$90 million annually in local sales tax from a successful 2004 ballot measure</li> </ul>	<p>provide it for themselves</p> <ul style="list-style-type: none"> <li>• State legislation creating the authority explicitly requires the city to reimburse for the cost of providing uncompensated care</li> <li>• Statute specifies that reimbursement will be no less than \$175 million per year, adjusted annually (since 1972) to account for increases in health care costs and changes in service volume</li> </ul>	<p>unreimbursed care</p> <ul style="list-style-type: none"> <li>• Annual allocation based on a percent of uncompensated care costs (the percentage is negotiated)</li> </ul>	<p>residents</p> <ul style="list-style-type: none"> <li>• Financed by ½ cent sales tax approved by voters in 1991 and a portion of property taxes</li> </ul>	<p>cannot exceed the level specified in the state constitution</p> <ul style="list-style-type: none"> <li>• County provides a negotiated indigent care subsidy financed through two property tax levies</li> </ul>	<p>patients; also a core value of the hospital</p> <ul style="list-style-type: none"> <li>• County provides a negotiated indigent care subsidy financed through two property tax levies</li> </ul>	<p>reimbursement formula is proposed to cover indigent care expenditures</p>

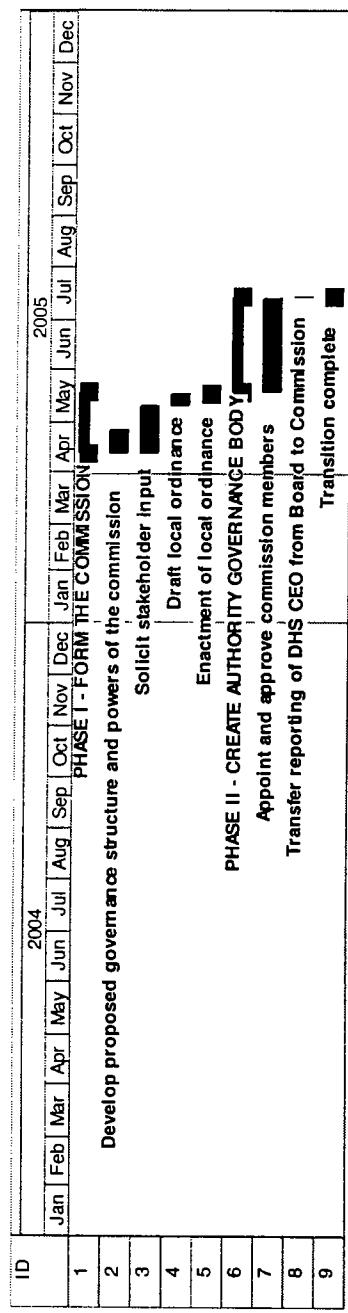
Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Dallas County, TX	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
<p><b>Managerial flexibility and autonomy</b></p> <ul style="list-style-type: none"> <li>Exempt from policies and operational rules of the county, including personnel, procurement, and contracting rules</li> <li>Not bound by county civil service and has sole authority in negotiating labor agreements (after expiration of agreement in effect at time of transfer)</li> <li>Reduction in legal obstacles to competitiveness contracting, civil purchasing, civil service, sunshine laws, budgeting, or support services</li> <li>Reduction in legal requirements (with certain exceptions); authority may establish the bidding qualifications for contracts greater than \$25,000</li> <li>Public records and public meetings laws apply (exemptions exist for trade secrets and negotiated payment rates)</li> <li>Retains county legal counsel</li> </ul>	<ul style="list-style-type: none"> <li>Hires CEO without approval</li> <li>Can adopt, alter, amend or repeal bylaws without approval</li> <li>Contracting and purchasing not governed by city rules</li> <li>Can participate in group purchasing initiatives</li> <li>Establishes and administers its own personnel program, including wage and benefit structure (employees are not unionized)</li> <li>Subject to open meetings and open record laws (few exemptions exist)</li> <li>Develops its own budget without approval (except for indigent care expenditures)</li> <li>May retain its own legal counsel</li> <li>Develops its own budget without approval</li> </ul>	<ul style="list-style-type: none"> <li>Can adopt, amend, or repeal bylaws without approval</li> <li>Contracting and purchasing must follow some public bidding</li> <li>Can participate in group purchasing initiatives</li> <li>Establishes and administers its own personnel program, including wage and benefit structure (employees are not unionized)</li> <li>Subject to open meetings and open record laws (few exemptions exist)</li> <li>Develops its own budget without approval (except for indigent care expenditures)</li> <li>May retain its own legal counsel</li> <li>Develops its own budget without approval</li> </ul>	<ul style="list-style-type: none"> <li>Not bound by county rules for contracting or purchasing, although must follow some public bidding procedures and County Commission approval is required for certain contracts</li> <li>Hires staff, sets compensation levels, and establishes personnel and management policies; County Commission can disapprove these policies</li> <li>Assumes primary role in labor negotiations, but County Commission must approve final contract</li> <li>Bound by open meetings and record laws (small exemption for strategic planning)</li> <li>Must use county security and legal services</li> <li>Can implement supporting services systems, but must determine the cost advantage of obtaining the services from the county before obtaining from a non-county source</li> </ul>	<ul style="list-style-type: none"> <li>Not bound by county contracting or purchasing rules, but use a process similar to the county system</li> <li>County Commissioner's Court may prescribe the method of making purchases or expenditures, if desired, and <u>may</u> approve certain contracts</li> <li>The District Board of Managers and Commissioner's Court currently approve all contracts over \$20,000</li> <li>Subject to open meeting laws</li> <li>Establishes and administers its own personnel program</li> <li>Budget must be approved by the Commissioner's Court</li> <li>Can pay for legal services through the county and employ additional legal counsel</li> </ul>	<ul style="list-style-type: none"> <li>Hires CEO without approval</li> <li>Use state bidding and purchasing procedures, but may adopt their own policies, with County Commission approval</li> <li>Can participate in group purchasing initiatives</li> <li>Adopts wage and salary schedules, determines benefits, and can pay reasonable expenses related to recruiting and retaining staff</li> <li>Follow open meetings and reporting rules (with some exemptions for trade secrets and competitive information)</li> <li>County Commission must approve the Authority's budget and may require revisions</li> <li>May retain counsel and institute legal action in its own name</li> </ul>	<ul style="list-style-type: none"> <li>Would have authority to approve non-material changes to the bylaws</li> <li>Contracting and purchasing would not be governed by county rules</li> <li>Would be allowed to create its own employment system and benefit programs; existing labor union representation would be recognized and the hospital would negotiate future labor agreements directly</li> <li>Public disclosure requirements would be similar to HCMC's competitors</li> </ul>
<p><b>Financing</b></p> <ul style="list-style-type: none"> <li>Facility ownership</li> <li>Property rights</li> <li>Taxing authority</li> <li>Revenue generation</li> <li>Acceptance of gifts</li> </ul>	<ul style="list-style-type: none"> <li>Can acquire and control the use of real and personal property and dispose of non-county-owned property (County Board of Supervisors retains control over use of the physical plant and facilities)</li> <li>May invest funds held in reserves in obligations of the government</li> <li>Can create subsidiary public benefit corporations</li> <li>May borrow funds</li> </ul>	<ul style="list-style-type: none"> <li>Can acquire and control the use of real and personal property and dispose of non-county-owned property (County Board of Supervisors retains control over use of the physical plant and facilities)</li> <li>May invest funds held in reserves in obligations of the government</li> <li>Can create subsidiary public benefit corporations</li> <li>Required to create</li> </ul>	<ul style="list-style-type: none"> <li>County owns real property</li> <li>Has the right to use and maintain property as needed</li> <li>No taxing power</li> <li>Can issue bonds and notes to raise revenue and can arrange for guarantees or insurance of its obligations</li> <li>Can participate in alliances and joint</li> </ul>	<ul style="list-style-type: none"> <li>Has title to the land, buildings and equipment</li> <li>Has taxing power, but the level is set by the Commissioner's Court</li> <li>May issue bonds with approval of the Commissioner's Court and the majority vote of electors, and issue certificates of obligation with</li> </ul>	<ul style="list-style-type: none"> <li>County-owned property would be leased to the authority</li> <li>County Board must approve any decision to dissolve, merge, consolidate, or transfer assets to an entity other than the county</li> <li>No taxing authority</li> <li>Ability to issue tax-exempt bonds, enter into joint ventures,</li> </ul>	

Alameda County (Oakland), CA	New York City, NY	Denver, CO	Miami-Dade County, FL	Cuyahoga County (Cleveland), OH	Hennepin County (Minneapolis), MN
<p>from the county</p> <ul style="list-style-type: none"> <li>• May accept contributions and grants</li> </ul>	<p>and sustain a capital reserve fund with financial assistance from the city as needed</p> <ul style="list-style-type: none"> <li>• Can accept gifts and grants</li> </ul>	<p>ventures and can create non-for-profit subsidiaries</p> <ul style="list-style-type: none"> <li>• Can accept gifts, grants, and loans</li> <li>• Governmental immunity</li> </ul>	<p>obligation to take affirmative action on the requests</p> <ul style="list-style-type: none"> <li>• Can accept gifts (County Commission must approve gifts of real property)</li> </ul>	<p>Commissioner's Court approval</p> <ul style="list-style-type: none"> <li>• May accept gifts and endowments to be held in trust</li> <li>• May create a charitable organization</li> </ul>	<p>and create subsidiaries with County Board approval</p> <ul style="list-style-type: none"> <li>• Can accept gifts, grants, and endowments</li> </ul>
<p><b>Public Accountability</b></p> <ul style="list-style-type: none"> <li>• Local government controls</li> <li>• Public reporting requirements or audits</li> </ul>	<p>Supervisors appoint and may remove members of the authority board, may change or amend the authority bylaws, and must approve the annual indigent care contract and subletting of property.</p> <ul style="list-style-type: none"> <li>• Authority must submit quarterly reports to the county that include information related to health system utilization and the level of indigent care provided</li> </ul>	<p>City government appoints and may remove members of the governing board</p> <ul style="list-style-type: none"> <li>• Transfer agreements between the authority and city require adherence to mission, prohibit sale of assets without permission, detail performance criteria for the transferred services, require payment for indigent care, and specify the process of dispute resolution</li> <li>• Authority has quarterly meetings with key city managers and has a designated staff member who serves as a liaison with city government</li> </ul>	<p>must approve appointment of board members, changes to bylaws, annual operating budget, acquisition/sale of property, major contracts, issuance or use of monies derived from the sale of bonds, employee compensation, and annual budget</p> <ul style="list-style-type: none"> <li>• Commission may disapprove of the authority's personnel and management policies</li> <li>• County Commission can investigate the affairs, conduct, accounts, records, and transactions of the authority</li> <li>• Authority must provide County Commission with an annual report and audited accounting of all receipts and disbursements; currently submit quarterly data</li> <li>• County Commission may appropriate any net income into the county's general revenues and transfer additional services and responsibilities to the authority</li> <li>• Commissioner's Court reserves the role of countywide health care planning</li> </ul>	<p>Commissioner's Court approves board members, changes in use, sale, and acquisition of property, and all contracts</p> <ul style="list-style-type: none"> <li>• District must submit an annual report on operations to the Commissioner's Court</li> <li>• County Commission may conduct inspections of facilities and records</li> </ul>	<p>County Commissioners (and two judges) approve board members, bidding procedures, annual operating budget (if the authority receives a county subsidy), and indigent care contract</p> <ul style="list-style-type: none"> <li>• Investments in securities and obligations must be approved by county investment advisory committee</li> <li>• County Board approves slate of Board members; can remove entire Board</li> <li>• Quarterly presentations to the County Board are required on health services plan, financial status, and provision of indigent care</li> </ul>

**Attachment III**

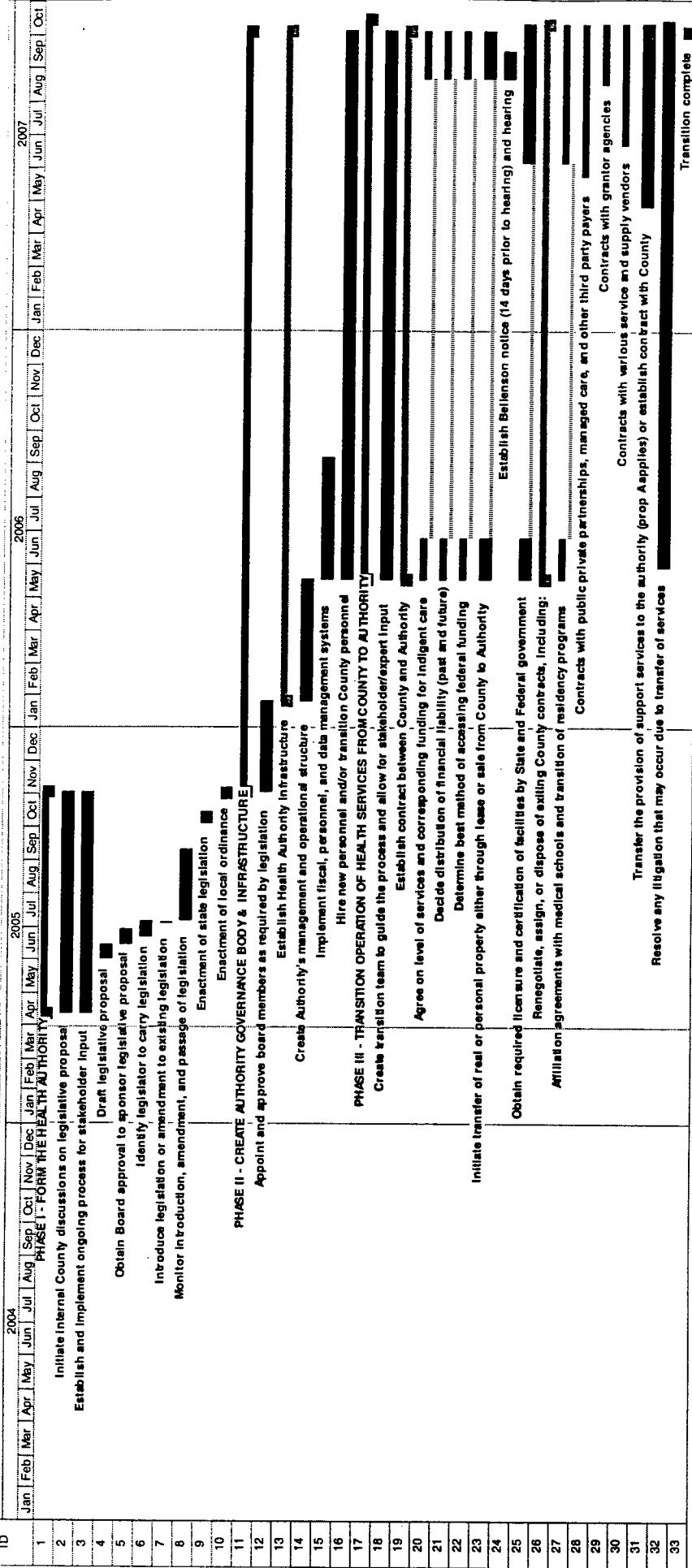
**DRAFT TIMELINES FOR ALTERNATIVE HEALTH GOVERNANCE MODELS**

**MODEL – HEALTH COMMISSION**

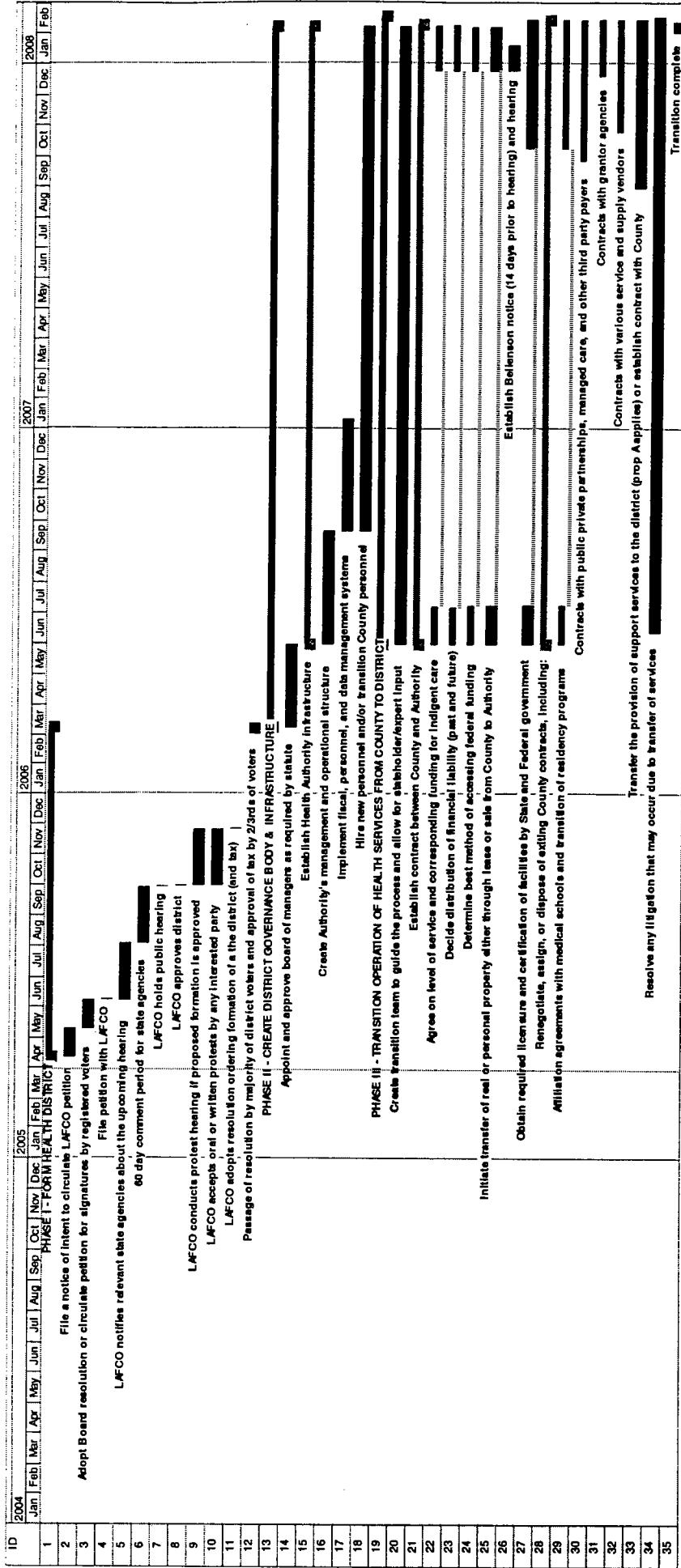


## MODEL – HEALTH AUTHORITY

ID	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct														
1	2004	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2005	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	2006	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	2007	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
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MODEL - HEALTH CARE DISTRICT



## MODEL – PRIVATE NON-PROFIT

ID	2004 Jan   Feb   Mar   Apr   May   Jun   Jul   Aug   Sep   Oct   Nov   Dec	2005 Jan   Feb   Mar   Apr   May   Jun   Jul   Aug   Sep   Oct   Nov   Dec	2006 Jan   Feb   Mar   Apr   May   Jun   Jul   Aug   Sep   Oct   Nov   Dec	2007 Jan   Feb   Mar   Apr   May   Jun   Jul   Aug   Sep   Oct   Nov   Dec
1				
2	Determine the proposed structure and design of the non-profit			
3	Initiate internal and stakeholder discussions and/or form governance committee			
4	Draft incorporation plan and articles of incorporation			
5	File articles of incorporation with the Secretary of State, stating purpose of proposed corporation.			
6	Draft the bylaws of the new corporation			
7	File for tax exempt status with the Internal Revenue Service			
8	File for employer identification number with IRS			
9	File an annual Statement by Domestic Nonprofit Corporation with Secretary of State			
10	PHASE II - CREATE DISTRICT GOVERNANCE BODY & INFRASTRUCTURE			
11	Appoint board of directors			
12	Establish non-profit infrastructure			
13	Adopt corporate bylaws			
14				
15	Elect officers			
16	Establish management and operational structure			
17	Establish fiscal, personnel, and data management systems			
18	Hire new personnel and/or transition County personnel			
19	PHASE III - TRANSITION OPERATION OF HEALTH SERVICES FROM COUNTY TO NONPROFIT			
20	Create transition team to guide the process and allow for state/older/expert input			
21	Establish contract between County and Authority			
22	Agree on level of service and corresponding funding for indigent care			
23	Decide distribution of financial liability (past and future)			
24	Determine best method of accessing federal funding			
25	Restructure relationship with physicians from direct employment to contractual (non-profits cannot employ physicians)			
26	Initiate transfer of real or personal property either through lease or sale from County to Authority			
27	Obtain required licensure and certification of facilities by State and Federal government			
28	Negotiate, assign, or dispose of existing County contracts, including:			
29	Affiliation agreements with medical schools and transition of residency programs			
30	Contracts with public private partnerships, managed care, and other third party payers			
31	Contracts with grantor agencies			
32	Contracts with various service and supply vendors			
33	Transfer the provision of support services to the district (prop A plus) or establish contract with County			
34	Resolve any litigation that may occur due to transfer of services			
35				
36	Transition complete			